From:

09/24/2012 15:22

#560 P.002/041

		AND HUMAN SERVICES & MEDICAID SERVICES	4	5	L 10/27/12	FORM	09/17/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		445498	B. WI	NG_		09/1	2/2012
	ROVIDER OR SUPPLIER NURSING HOME			26	EET ADDRESS, CITY, STATE, ZIP CODE 51 NORTH STREET RISTOL, TN 37625		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241 SS=E	The facility must premanner and in an elenhances each resifull recognition of his recognition of his REQUIREMENT by: Based on observation failed to promote dimeal service in the residents in one of the findings included to be compared to the finding room, revealed served upon arrival present at the time were not served as floor at 12:25 p.m. Assistants (CNA) and Nurse (LPN) were a set-up and feeding, room and on the sein the dining room (present to feed the family member retriarrived on the floor, clothing protector, but in the dining station, and the compared to the floor, clothing protector, but in the compared to the floor, clothing protector, but in the compared to the floor, clothing protector, but in the compared to the floor, clothing protector, but in the clothing protector in the clothing	omote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality. It is not met as evidenced ion and interview the facility gnity and individuality during dining room for twelve two dining areas. It is not met as evidenced ion and interview the facility gnity and individuality during dining room for twelve two dining areas. It is not met as evidenced ion and interview the facility gnity and individuality during dining areas. It is not met as evidenced ion and interview the facility gnity and individuality during dining areas. It is not met as evidenced in a second floor for twelve from 12:17 points, in the second floor the facility was soon as they arrived on the formal for halls. One resident the formal formal from the eved the tray as soon as it assisted the resident with a corrowed a chair from the fed the resident funch. The room were awaiting their	F	241	What corrective action(s) will be accompanies those residents found to have been affect deficient practice. No negative outcomes were noted thru of More tables were placed in the dinning roghto/12 by maintenance. How will you identify other residents have potential to be affected by the same define practice and what corrective action will be alleged deficient practice. Potential affected resident will be identified observation. What measures will be put into place or a systematic changes you will make to ensure deficient practice does not occur. Starting on 9/24/12 the Unit Managers will meal services daily for two weeks and the four weeks and then PRN to ensure correct procedures and resident dignity during dispense of the policy of the polic	servation. om on ing the clent e taken. cted by this ed thru what ure that the ill monitor in weekly for it dinning aning are se, or Night in correct uring dinning ced on the are served the floor.	
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	i	TITLE	····	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	AND DECLERATE OF THE PARTY OF T	$\overline{}$			<u> </u>	<u>, u938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		445498	8. WI	NG_		09/1	2/2012
	PROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 161 NORTH STREET BRISTOL, TN 37625		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 242 SS=D	meal tray from the (#25) receiving a trate (#25), seated at the same residents to finish the seates after the trate (#25) received their meals and wath their meals and wath their meals and wath their meals and wath their meals and head received the seates interact with member inside and outside the about aspects of his are significant to the trace of the seated on facility potacility failed to ensure the seates of the se	sident (#57) receiving their family and the second resident ay from a staff member was other eight minutes elapsed I fourth residents (#s 135 and ame table with resident #25, neals and assisted by staff with sident (#94) waited for other neir meal for a bedside table to This resident waited 40 ays arrived on the floor to ent #94 stated "I'm hungry its seated around the resident #3 at the time of the residents waited for inched as other residents ate. TERMINATION - RIGHT TO be right to choose activities, and plans of care; ers of the community both the facility; and make choices so or her life in the facility that its resident. IT is not met as evidenced blicy review and interview the are personal choices were ident (#84) of thirty-four		241	ensure the deficient practice will not recommend to the Quality Assurance Committee on a basis for six months. The Quality Assurance Committee (Admin Director of Nursing, and Assistant Director Medical Director, Business Office Manager Manager, Activities Manager, Social Servic Maintenance Director, and Therapy Managmake recommendations to revise or improprocess and determine when compliance is achieved.	udit findings monthly istrator, r of Nursing, r, Dietary tes Director, ger) will eve the has been ished for ted by the rse on the 3/12, ng the tent te taken. g and all tuss the to identify	COMPLANS
;	5	:		!	!	;	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/17/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445498 09/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 242 Continued From page 2 F 242: Resident #84 was admitted to the facility on April What measures will be put into place or what 28, 2012, with diagnoses including Cellulitis of systematic changes you will make to ensure that the Toe, Depressive Disorder, Failure to Thrive, deficient practice does not occur. Diabetes Mellitus, Hyperglycemia, History of Any visitation issues identified in the care plan meeting Urinary Tract Infections and Suicidal Ideation. the Social Services Director will complete a grievance form and start the grievance procedure. Review of facility policy entitled Access and Visitation revealed..."You have the right to The DON/ADON, Unit Managers, MDS Nurse, or Night immediate access to any...family members and Supervisor will educate all staff on resident rights and other relatives"... the visitation policy by 9/28/2012. Interview with resident #84 on September 11, Starting after 9/28/12 staff will be in serviced prior to 2012, at 10:22 a.m., in resident's room revealed being allowed to return to the floor. there had been an incident approximately three months ago when the resident's niece came to In-service will be added to the orientation packet. visit with two children at 8:15 p.m., and the resident became upset when her niece and family How the corrective action(s) will be monitored to were asked to leave by Licensed Practical Nurse ensure the deficient practice will not recur. (LPN) #4. Further interview revealed the resident told LPN #4 the family had come a long way to The Social Services Director will report any visitation grievances to the QA committee monthly for 3 months visit and rarely could visit. and PRN. Interview with the Director of Nursing (DON) on The Quality Assurance Committee (Administrator, September 12, 2012, at 9:50 a.m., in the DON Director of Nursing, and Assistant Director of Nursing, office revealed the DON was unaware of the Medical Director, Business Office Manager, Dietary incident. Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will Telephone interview on September 12, 2012, at make recommendations to revise or improve the 12:30 p.m., with LPN # 4 revealed the LPN had process and determine when comptiance has been asked the family to leave because they had achieved. arrived after the posted visiting hours. LPN #4 stated the resident became upset and the LPN requested the family leave twice; once when they first arrived, and again ten minutes later.

Interview with the DON on September 12, 2012, at 12:35 p.m. confirmed the facility had failed to

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		445498	B. WIN	IG		09/1	2/2012
	PROVIDER OR SUPPLIER DL NURSING HOME			261	EET ADDRESS, CITY, STATE, ZIP CODE 1 NORTH STREET RISTOL, TN 37625		22012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 246 SS=D	visitors. 483.15(e)(1) REAS OF NEEDS/PREFE A resident has the reservices in the facility accommodations of preferences, except the individual or othen endangered. This REQUIREMENT by: Based on observate failed to ensure the one resident (#114) reviewed. The findings included Resident #114 was August 27, 2012, with Folliculitis, Weaknes Depression, Fluid Reflux Disease, Vita Fever, Pain, and Hy Medical record reviewed Set (MDS) dated Aprinterview for Mental indicating severe controls.	SONABLE ACCOMMODATION ERENCES right to reside and receive lity with reasonable of individual needs and obt when the health or safety of the residents would be solved the residents would be solved the residents within reach for the call light was within reach for of thirty-four residents ed: s admitted to the facility on with diagnoses including tess, Congestive Heart Failure, Retention, Hypertension, Arthralgia, Gastroesophageal amin D Deficiency, Dementia,	F 2	246	F246 What corrective action(s) will be accompthose residents found to have been affed deficient practice. Call light was immediately placed in reside Resident was educated on the use of call. How will you identify other residents hapotential to be affected by the same definantice and what corrective action will. All resident have the potential to be affected and maintenance to ensure call lights are functioning on 9/21/12. What measures will be put into place or systematic changes you will make to ensure deficient practice does not occur. Starting on 9/24/12 the Unit Managers were rounds to ensure call bells are in reach. The nursing staff will be educated by the Unit Managers, MDS Nurse, or Night Supplied placement and response by 9/28/12. Starting after 9/28/12 staff will be in service will be added to the orientation in service will be added to the orientation.	lent's reach. bell, voing the ficient be taken. cted. ed by nursing e in reach and what sure that the vill make daily DON/ADON, ervisor on call	
	Interview with the re	esident on September 10,					

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/17/2012 1 APPROVED
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
	·	445498	B. WING		09/4	2/2042
	PROVIDER OR SUPPLIER L NURSING HOME		26	EET ADDRESS, CITY, STATE, ZIP COI 51 NORTH STREET RISTOL, TN 37625		2/2012
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F 272 SS=D	revealed an awaren for and how to use if for and how to use if for and how to use if 2012, at 2:39 p.m., revealed the call light the bed behind the interview with the re 2012 at 2:40 p.m., is resident was unable prompted. Observation of the resident was unable prompted. Observation of the resident the call light hanging behind the mattress interview with Licenson September 11, 2 resident's room confreach of the resident 483.20(b)(1) COMP ASSESSMENTS The facility must cora comprehensive, acreproducible assess functional capacity. A facility must make assessment of a resident assessment of a resident assessment by the State. The asleast the following:	in the resident's room less of what the call light was it. Ident #114 on September 10, in the resident's room int hanging over the back of mattress. Issident on September 10, in resident's room revealed the it to reach the call light when resident on September 11, in the resident's room revealed gover the back of the bed Issed Practical Nurse (LPN) #2 Issed Practical Nurse (F 272	How the corrective action(s) will be ensure the deficient practice will not the DON/ADON, Quality Assurance round findings to the Quality Assuramenthly. The Quality Assurance Committee (A Director of Nursing, and Assistant Di Medical Director, Business Office Mi Manager, Activities Manager, Social Maintenance Director, and Therapy make recommendations to revise or process and determine when complianchieved.	ot recur. Nurse will report nce Committee Administrator, Irector of Nursing, anager, Dietary Services Director, Manager) will	10 22 Ha

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BU}LDING	PLE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
		445498	B. WING		0014	1212042	
	PROVIDER OR SUPPLIER L NURSING HOME		26	EET ADDRESS, CITY, STATE, ZIP CO 31 NORTH STREET RISTOL, TN 37625		1 <u>2/2</u> 012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
F 272	Continence; Disease diagnosis a Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional asses areas triggered by to Data Set (MDS); an	patterns; peing; g and structural problems; and health conditions; al status; and procedures; ummary information regarding asment performed on the care the completion of the Minimum	F 272	What corrective action(s) will be acceptose residents found to have been deficient practice. Resident # 114 had dental assessment updated by the ADON on 9/19/12. How will you identify other resident potential to be affected by the same practice and what corrective action of All resident have the potential to be affected by Nursing Admit dental assessments will be completed ensure all assessments are current arrare plan updated. What measures will be put into place systematic changes you will make to deficient practice does not occur. Starting on 9/24/12 the DON/ADON of will make weekly audits of dental assessments are completed correctly assessments are completed correctly assessments are completed correctly	affected by the at and care plan as having the edificient will be taken. affected. Inistration of d by 10/8/12 to and accurate with the ensure that the cor Unit Managers essment on new are the		
; ; ;	by: Based on medical r the facility failed to a status of one reside residents reviewed i The findings include Resident # 114 was July 31, 2012, with o			The DON/ADON, Unit Managers, MD. Supervisor will in-service licensed states assessments to be completed by 9/28 CNAs will be educated by the DON/AMANAGERS, MDS Nurse, or Night Supercommunicating to the nurse with any concerns including dental concerns b. Starting after 9/28/12 staff will be in being allowed to return to the floor.	ff on dental 8/12. ADON, Unit rvisor on r and all resident y 9/28/12. serviced prior to		

CTATEMEN	TOE DEFINITION	- THE TOTAL OF THE TOTAL				<u>OMR NO</u>	<u>). U9</u> 38-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445498	B. WI	4G _		09/	12/2012
	PROVIDER OR SUPPLIER L NURSING HOME SUMMARY STA (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	l0	26 B	EET ADDRESS, CITY. STATE, ZIP CODE 61 NORTH STREET RISTOL, TN 37625 PROVIDER'S PLAN OF CORRE	CTION	(X5)
TAG	REGULATORY OR L	SC (DENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	COMPLETION
	dental/oral health producted the resident issues. The resident hospital on August and syncope. The resident was transferred bace 2012. Medical record 2012, admission as resident was edented dentures. Medical record reviet (NP) Daily Progress 2012, revealed the food textures and consident's prescribe pureed. Interview with Certifulation of the synchronic is prescribed pureed. Interview with Certifulation of the synchronic is prescribed in t	ew of an admission July 31, 2012, revealed the ortion of the assessment int had teeth and no dental int was transferred to the 4, 2012, due to hypoglycemia esident was hospitalized and ex to the facility on August 10, and review of the August 10, sessment indicated the ulous (no teeth) and had ew of a Nurse Practitioner's inote, dated August 30, resident had difficulty with newing. The NP changed the id diet from mechanical soft to ied Nursing Assistant (CNA) 2, at 3:05 p.m. revealed the es and following the August 4, in. The CNA stated the es and the CNA assisted the es and the CNA assisted the es and the CNA did not ent having dentures in the ident's readmission to the in, 2012.	F	272	How the corrective action(s) will be mo ensure the deficient practice will not re The DON/ADON, Quality Assurance Nurs audit findings to the Quality Assurance Comonthly. The Quality Assurance Committee (Admi Director of Nursing, and Assistant Direct Medical Director, Business Office Manage Manager, Activities Manager, Social Serv Maintenance Director, and Therapy Marmake recommendations to revise or improcess and determine when compliance achieved.	secur. Se will report Committee Inlstrator, For of Nursing, For, Dietary Vices Director, Forove the	10/22/12
: : : :	September 12, 2012	rector of Nursing (DON) on 2, at 2:10 p.m., in the onfirmed the admission					- -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD			ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		445498	B. WIN	16		00/4	2/2012	
	PROVIDER OR SUPPLIER		•	26	EET ADDRESS, CITY, STATE, ZIP CODE 61 NORTH STREET RISTOL, TN 37625		22012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	COMPLETION DATE	
F 272	Continued From pa	oe 7	i		F279		i	
F 279	assessments were	conflicting and the resident less that the facility failed to on the assessment ()(1) DEVELOP	: . F2	279	What corrective action(s) will be accommodate those residents found to have been affined deficient practice. Resident # 4 had care plan updated on 9 Activities Director.	ected by the		
	A facility must use to to develop, review a comprehensive plar	he results of the assessment and revise the resident's a of care.	İ		Residents # 84, and # 32 had care plans MDS nurse on 9/13/12.	updated by the	•	
	plan for each reside objectives and time!	velop a comprehensive care int that includes measurable lables to meet a resident's			How will you identify other residents he potential to be affected by the same de practice and what corrective action will	ficient		
:	medical, nursing, ar needs that are ident assessment.	id mental and psychosocial ified in the comprehensive			All resident have the potential to be affe			
:	The care plan must to be furnished to at	describe the services that are tain or maintain the resident's			MDS Nurses, and Unit Managers will be 10/23/12 to ensure care plans are up to	•		
! ! !	highest practicable psychosocial well-be §483.25; and any se	ohysical, mental, and eing as required under ervices that would otherwise			What measures will be put into place or systematic changes you will make to en deficient practice does not occur.			
	due to the resident's	483.25 but are not provided exercise of rights under ne right to refuse treatment			Starting on 9/24/12 the DON/ADON will charts/week x 6 weeks then 2 charts/we then randomly to ensure care plans are	ek x 6 weeks		
 	This REQUIREMEN	T is not met as evidenced			Licensed nurses, MDS nurses, and Care I be educated by the DON/ADON on revis when changes occur by 9/28/12.			
	Based on medical rethe facility failed to re	ecord review and interview evise the care plan to for #84, and #32) of thirty-four a stage 2.			MDS nurses and Care Plan team will be on the DON/ADON on identifying and address management and activities on the care \$9/28/12.	essing pain		
: 	The findings include	d:		i	Starting after 9/28/12 staff will be in ser being allowed to return to the floor.	viced prior to		
	Resident #4 was adı	mitted to the facility on April		: 	In-service will be added to the orientation	on packet.		

CTATEMEN	T OF DEFICIENCE					OWR NO	<u>. 0938</u> -0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
<u>-</u>		445498	B. Wit	NG_		09/1	2/2012
	PROVIDER OR SUPPLIER L NURSING HOME			2	REET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET BRISTOL, TN 37625		
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	Heart Failure, Hype and Muscle Weakn Medical Record revice Completed on April don't like to do anyt Continued record recare plan updated documentation to reinterventions to add Interview with the failure (MDS) coordinator (21 a.m., in the MDS resident's care plan Resident #84 was a 28, 2012, with diagr Toe, Depressive Diabetes Mellitus, Hurinary Tract Infection Medical record revie (MDS) quarterly reviewealed pain was liconstant. Medical record reviewed problem. Interview with the Mind 12, 2012 at 1:00 p.n confirmed the facility comprehensive plan pain management.	nosis including Congestive rtension, Failure to Thrive, ess. iew of an activity evaluation 23, 2012, revealed "I usually hing not really social" eview of the current resident fully 19, 2012, revealed no effect specific goals and ress activities. Incitity Minimum Data Set on September 12, 2012, at 10: office confirmed the did not address activities. Incitity Minimum Data Set office confirmed the did not address activities admitted to the facility on April noses including Cellulitis of sorder, Failure to Thrive, hyperglycemia, History of ons and Suicidal Ideation. Incitity Minimum Data Set is a serious and Suicidal Ideation. In office confirmed the dated July 15, 2012, sted as frequent, but not set of care plan dated July 19, pain management as a post coordinator on September of the MDS office of failed to develop a of care including addressing demitted to the facility on May demitted to the facility on May	F	279	How the corrective action(s) will be more ensure the deficient practice will not recommend to the DON/ADON, Quality Assurance Committee (Admit John Start Director of Nursing, and Assistant Director Medical Director, Business Office Manager, Activities Manager, Social Servi Maintenance Director, and Therapy Manmake recommendations to revise or impurposess and determine when compliance achieved.	e will report committee nistrator, or of Nursing, er, Dietary ices Director, ager) will rove the	completed a

DEPAR	FORM): 09/17/2012 APPROVED				
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		445498	B. WI	ING	0011	1212040
	PROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIF 261 NORTH STREET BRISTOL, TN 37625		2/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACT	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	Airway Obstruction, Hypertension. Medical record revie Data Set dated June resident was able to understood what was Medical record revie September 6, 2012, to indicate the resident the dentures Observation and into 2012, at 9:06 a.m., a	worrhage, Diabetes, Chronic Vascular Dementia, and ew of the quarterly Minimum to 10, 2012, revealed the make needs known, and	F:	279		
F 280 SS=D	dentures were too lottime," and would like Interview on Septerr with the Director of Noffice, confirmed the 6, 2012, did not addidentures. 483.20(d)(3), 483.10 PARTICIPATE PLAIT The resident has the incompetent or other incapacitated under participate in planning changes in care and A comprehensive call within 7 days after the comprehensive asset	to see a dentist. Aber 12, 2012, at 1:55 p.m., Aursing (DON), in the DON's Care Plan dated September ress the care of the resident's A(k)(2) RIGHT TO NNING CARE-REVISE CP Tight, unless adjudged wise found to be the laws of the State, to ag care and treatment or treatment.	F2	F280 What corrective action(s) will be those residents found to have be deficient practice. Resident # 50 had care plan updated on 9/13/12. How will you identify other residential to be affected by the sepractice and what corrective action and what corrective actions are affected. 100% review of resident care plan DON/ADON, MDS Nurses, and Undone by 10/23/12 to ensure care	een affected by the ated by the MDS nurse dents having the same deficient tion will be taken, the potential to be as with behaviors by and Managers will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) - COMPLETION DATE
	for the resident, an disciplines as deter and, to the extent p the resident, the relegal representative	age 10 ered nurse with responsibility d other appropriate staff in rmined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F	280	What measures will be put into place or a systematic changes you will make to ensu deficient practice does not occur. Starting on 9/24/12 the DON/ADON will at charts/week x 6 weeks then 2 charts/week then randomly to ensure behavior care pladate. Licensed nurses and MDS nurses will be ed	udit S k x 6 weeks ins are up to	
	by: Based on medical the facility failed to (#50) resident of thi stage 2. The findings include Resident #50 was a 6, 2012, with diagnor Disorder, Hypertens and Osteoporosis. Medical record reviews	admitted to the facility on June oses including Mental sion, Congestive Heart Failure, sew of the Quarterly Minimum			the DON/ADON, or Night Supervisor on revelan when behaviors occur by 9/28/12. Starting after 9/28/12 staff will be in service being allowed to return to the floor. In-service will be added to the orientation of the theoretic will be monited ensure the deficient practice will not recurrently action of the DON/ADON, Quality Assurance Nurse audit findings to the Quality Assurance Commonthly for 3 months. The Quality Assurance Committee (Adminitation of Nursing, and Assistant Director)	ed prior to packet. cored to r. will report militee strator, of Nursing,	
	Data Set (MDS) dat the resident had ph directed toward other Medical record revie August 30, 2012, re the resident's behave Interview on Septem with Registered Nur	ted August 26, 2012, revealed sysical behavior symptoms ers. ew of the care plan dated evealed no update to reflect			Medical Director, Business Office Manager, Manager, Activities Manager, Social Service Maintenance Director, and Therapy Managemake recommendations to revise or improprocess and determine when compliance hachieved.	es Director, (er) will ve the as been	10/23/12 50mbleyey

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING	(X3) DATE SURVEY COMPLETED	
44549	8. WI	NG	09/12/2012	
NAME OF PROVIDER OR SUPPLIER BRISTOL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET BRISTOL, TN 37625		
(X4) ID SUMMARY STATEMENT OF DEFICIENCE PREFIX {EACH DEFICIENCY MUST BE PRECEDED B TAG REGULATORY OR LSC IDENTIFYING INFORM	Y FULL PREF		HOULD BE COMPLETION	
F 280 Continued From page 11 reflect the resident's behaviors. F 281 483.20(k)(3)(i) SERVICES PROVIDED PROFESSIONAL STANDARDS The services provided or arranged by must meet professional standards of quantum meet	ine facility uality. ridenced ervation, lop an or falls and ur lillity on ting Fall n, History of on, and Evaluation esident was otes dated aled the ry. at 11:02 mplained of	What corrective action(s) will be accordinate those residents found to have been all deficient practice. Resident # 135 had care plan updated nurse on 9/13/12. How will you identify other residents is potential to be affected by the same of practice and what corrective action will be affected. 100% review of all residents with interivill be done by DON/ADON, MDS Nurse Managers to ensure they are up to date. What measures will be put into place of systematic changes you will make to edeficient practice does not occur. Starting on 9/24/12 the DON/ADON with charts/week x 6 weeks then 2 charts/withen randomly to ensure interim care produce. Licensed nurses and MDS nurses will be the DON/ADON or Night Supervisor on plan for any resident that has a fall by Starting after 9/28/12 staff will be in sebeing allowed to return to the floor. In-service will be added to the orientation.	ifected by the by the MDS having the deficient fill be taken. he potential to m care plans es, and Unit de by 10/15/12. for what finsure that the li audit 5 eek x 6 weeks fill and to eeducated by updating a care fi/28/12. rviced prior to	

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OTATEMEN	T 0.0	T THE BLOW WE DELIVICES				OMB NO	<u>. 0938</u> -0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPL	URVEY
		445498	B. Wil	NG_		09/1	2/2012
	PROVIDER OR SUPPLIER L NURSING HOME			20	REET ADDRESS, CITY, STATE, ZIP CODE 61 NORTH STREET BRISTOL, TN 37625	1 44.	2.2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OUILD BE	(X5) COMPLETION DATE
F 309	Interview on Septer with Registered Nur room, confirmed the Care did not addres pain. 483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessary or maintain the high mental, and psychological with the resident must provide the necessary maintain the high mental, and psychological with the resident must provide the necessary maintain the high mental, and psychological with the resident must provide the necessary maintain the high mental, and psychological maintain the resident must provide the necessary maintain the high mental, and psychological materials are resident must provide the necessary maintain the high mental materials are resident must provide the necessary materials and psychological materials are resident must provide the necessary must provide the necessary materials are resident must provide the necessary materials are resident must provide the necessary materials are resident must provide the necessary	D12, revealed no interventions dent's risk for falls or pain. The pain of the conference of the resident's Interim Plan of the resident's risk for falls or the resident fall of the resident fall		309	How the corrective action(s) will be more ensure the deficient practice will not recommend the DON/ADON, Quality Assurance Nurse audit findings to the Quality Assurance Committee (Admir Director of Nursing, and Assistant Director Medical Director, Business Office Manager Manager, Activities Manager, Social Servi Maintenance Director, and Therapy Manamake recommendations to revise or improrocess and determine when compliance achieved.	e will report ommittee nistrator, or of Nursing, er, Dietary ices Director,	comp. ted
	by: Based on medical rand interview, the faphysician's orders for scale insulin for one ensure proper positi #132) of thirty-four rather findings include Resident #51 was arroctober 13, 2006, will Diabetes and Schize Observation on Septensed Picensed P	dmitted to the facility on its diagnoses including			What corrective action(s) will be accompthose residents found to have been affed efficient practice. Resident # 51 had an order obtain to conscale on 9/11/12. Resident # 135 was fitted for a wheel chaplaced on 9/10/12. Resident # 132 had bed replaced with an on 9/12/12.	cted by the tinue stiding tir and cushion	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/17/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445498 09/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 309 Continued From page 13 F 309 of 179. How will you identify other residents having the potential to be affected by the same deficient Interview on September 11, 2012, at 5:10 p.m., practice and what corrective action will be taken. with LPN #2 revealed the resident was to receive Humalog insulin 2 units per sliding scale related 100 % review of physician recapitulation orders for to the blood sugar of 179, in addition to Humalog September will be done by the DON/ADON, and Unit 10 units ordered to be administered with meals. Managers to ensure orders are correct by 9/30/12. Medical record review of the September 2012. 100% review of all residents for positioning will be physician's recapitulation orders revealed the done by the DON/ADON, Restorative nursing, and resident was to receive Humalog insulin 10 units Therapy by 9/30/12. subcutaneously (by injection) with meals. Continued review of the September 2012. What measures will be put into place or what physician's recapitulation orders revealed no systematic changes you will make to ensure that the orders for the resident to receive sliding scale deficient practice does not occur. insulin. Starting on 9/24/12 the DON/ADON will audit 5 Medical record review of a Subcutaneous Sliding charts/week x 6 weeks then 2 charts/week x 6 weeks Scale Insulin Order Set, signed by the physician then randomly to ensure physician recapitulation on March 26, 2012, revealed the resident was to orders are correct. have the blood glucose checked before meals Starting on 9/24/12 the Unit Managers will make and at hour of sleep, and if the blood sugar was rounds to ensure correct positioning for residents in 151 - 200 the resident was to receive 2 units of the chair or bed. . Humalog insulin. Licensed nurses will be educated by the DON/ADON. Observation on September 11, 2012, at 6:35 Unit Managers, MDS nurse, or Night Supervisor on p.m., revealed LPN #2 administered Humalog 12 checking physician recapitulation orders to ensure all units subcutaneously into the resident's right arm. orders have been carried forward by 9/28/12. Interview on September 12, 2012, at 7:30 a.m., Starting after 9/28/12 staff will be in serviced prior to with the Director of Nursing confirmed there was being allowed to return to the floor. no current physician's order to administer sliding scale insulin to the resident at the time of the in-service will be added to the orientation packet. observation on September 11, 2012. Resident #135 was admitted to the facility on August 31, 2012, with diagnoses including Fall

with Right Hip Injury, Bilateral Leg Pain, History of

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET	12/2012 (X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRISTOL NURSING HOME 261 NORTH STREET	
BRISTOL, TN 37625	(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
Deep Venous Thrombosis, Hypertension, and Urinary Tract Infection. Observation on September 10, 2012, at 2:20 p.m., revealed the resident seated in a wheelchair without a cushion in the seat of the wheelchair. Continued observation revealed the resident's right leg was internally rotated and there were no foot or leg rests located on the wheelchair. Observation and interview with the resident on September 10, 2012, at 2:25 p.m., in the dining room, revealed the resident's right leg and bottom feit uncomfortable. Observation and interview on September 10, 2012, at 2:30 p.m., with Licensed Practical Nurse (LPN) #1, confirmed there were no leg rests or foot rests on the resident's wheelchair, and there was no cushion in the seat of the wheelchair. Observation on September 10, 2012, at 2:40 p.m., revealed the therapy department to evaluate the resident to the therapy department to evaluate the resident for a different wheelchair/positioning. Medical record review of a Physical Therapy fitted pt. (patient) for a proper fitting w/c" Interview on September 12, 2012, at 8:40 a.m., with Physical Therapist #1, in the conference room, revealed the Physical Therapist had evaluated the resident for a proper fitting wheelchair on September 10, 2012. Continued interview revealed the resident needed a taller	competei

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES					FORM): 09/17/2012 APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		LTIPLE CONSTRUCTIO	N	OMB NO (X3) DATE S COMPL). 0938-0391 SURVEY
		445498	B W	NG	·		00/	100000
NAME OF	PROVIDER OR SUPPLIER		!	s	TREET ADDRESS, CIT	Y, STATE, ZIP CODE		12/2012
BRISTO	L NURSING HOME				261 NORTH STREE BRISTOL, TN 370	т		į
(X4) ID PREFIX TAG	! {EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	JD PREF TAG	ΊX	(EACH COR	R'S PLAN OF CORR RECTIVE ACTION SI RENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	wheelchair with a lo	nger seat due to the	F	30	9:		·	
	and a seat cushion. confirmed the reside	nd a leg rest to the right side Continued interview ent was not positioned of the observation on						
	Resident #132 was 24, 2012, after a fall including Aftercare	admitted to the facility August admitted to the facility August at home, with diagnoses Traumatic Left Hip Fracture, Weakness and Childhood			; ; ; ;			
	(MDS) revealed the intact with a BIMS (E Status) score of 15/	ew of the Minimum Data Set resident was cognitively Brief Interview for Mental 15, required two persons' sfers, and one person's ing and dressing.			Print a mark			
	Admission Assessm revealed the residen	w of the Social Services ent dated August 24, 2012, t had lived independently at I and hospitalization to repair						
	resident resting supi comfortable and able stated, "It's a cránk t	resident's room on and 12, 2012, revealed the ne in bed. When asked if to sit up, the resident ped (manual crank) and I to raise the head of the bed."						
•	12, 2012, at 12:15 p. the resident was not bed independently to an electric bed.	it Manager on September m., in the Hallway, confirmed able to raise the head of the sit up in bed and required						
F 323	483.25(h) FREE OF	ACCIDENT	F 3	323	3		:	

From:

09/24/2012 15:31

#560 P.018/041

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE SI COMPLE	
		445498	B. WIN	G	09/1:	2/2012
	ROVIDER OR SUPPLIER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIF 261 NORTH STREET BRISTOL, TN 37625		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323 SS=D	The facility must en environment remain as is possible; and adequate supervision prevent accidents. This REQUIREMENT by: Based on observat Safety Data Sheets failed to safely store beauty shop. The findings include Observation on Separation on Separati	VISION/DEVICES Issure that the resident his as free of accident hazards each resident receives on and assistance devices to NT is not met as evidenced lion, review of the Material I, and interview, the facility e chemicals in the facility ed: Itember 10, 2012, at 10:53 door to the beauty shop was ed. Continued observation ing items were located on the ty shop: a one pound 2 ounce r, approximately 1/2 full; a of Selsun Blue shampoo, ull; a sixty-four ounce bottle of hampoo, approximately 1/4 in approximately eight ounces ctant; and a hair clipper ctrical outlet. Continued ed there were no residents in int to the beauty shop. rial Safety Data Sheet (MSDS)	F3	What corrective action(s) will be those residents found to have be deficient practice. No residents were affected. How will you identify other residential to be affected by the spractice and what corrective act All residents had the potential to Beauty shop was locked and the What measures will be put into systematic changes you will mail deficient practice does not occustarting on 9/24/12 the CEO will dally and PRN to ensure it is lock placed away. On 9/10/12 the beautician was eon not leaving the beauty shop unattended and keeping chemical away.	dents having the same deficient clon will be taken. be affected. beauticlan in serviced. place or what the r. check the beauty shop ed and chemicals are	
:	for the glass cleane Overexposure - Cor	r revealed "Effects of nditions to Avoid: May cause		: : :		

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES			PRINTED FORM	0: 09/17/2012 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	MULTIPLE CONSTRUCTION III.DING	OMB NO (X3) DATE S COMPL). 0938-0391 SURVEY
NAME OF F	ROVIDER OR SUPPLIER	445498	B. WI			12/2012
	NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CO 261 NORTH STREET BRISTOL, TN 37625	DE.	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLETION DATE
	Inhalation of productivitation. Avoid conprolonged or repeat swallow. Avoid breat thoroughly after han by Use: Use of this preexisting skin, eye including asthma and Storage: Keep out of Review of the MSDS Treatment Shampood used for the treatmetiritant and prolonge burns, irritation, and sensitivity reactions, may cause gastroint Measures - Eyes: In eyes with plenty of with Seek medical attentification. In gestion: In commediate medical attention of exposure. If signs immediate medical attention of exposure of the MSDS Raspberry Almond Symptoms of Exposingested. May cause irritation Emergence ingested, rinse mout	May be harmful if swallowed. It mist may cause respiratory tact with eyes. Avoid ed contact with skin. Do not athing product mist. Wash idling. Conditions Aggravated product may aggravate e and respiratory disorders and dermatitis Handling & if reach of children" It is an eye d skin contact may produce dermatitis. It may cause Ingestion of large amounts testinal upset First Aid in case of eye contact, flush vater for at least 15 minutes. It is in if irritation continues. It is incontinue use. Flush mounts of water. Keep away ranes, broken or irritated ase of ingestion, seek attention or contact Poison alation: Remove from source is of toxicity occur, seek attention or contact Poison alation: Remove from source is of toxicity occur, seek attention or contact Poison	F:	How the corrective action(s) will be ensure the deficient practice will not the CEO will report audit findings to Assurance Committee monthly for 3. The Quality Assurance Committee (A Director of Nursing, and Assistant Dir Medical Director, Business Office Ma Manager, Activities Manager, Social S Maintenance Director, and Therapy 8 make recommendations to revise or process and determine when complia achieved.	t recur. the Quality months and PRN. dministrator, rector of Nursing, nager, Dietary Services Director, Manager) will	Compatient

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/17/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445498 09/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ΙD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 323 Continued From page 18 F 323 seek medical attention. In case contact with eyes or skin causes irritation, discontinue use and flush with water for 10 minutes. If discomfort persists, seek medical attention..." Review of the MSDS for barbicide revealed "...Health Hazards: Eyes: Burning sensation. watering, or redness...Inhalation: Prolonged inhalation exposure may cause nausea, dizziness or disorientation...Precautions for Safe Handling and Use, Handling: Avoid ingestion and eve contact. Storage: Keep out of reach of children..." Observation and interview on September 10, 2012, at 10:55 a.m., with the hairdresser confirmed the door to the beauty shop was open and unattended. Observation and interview on September 10, 2012, at 11:08 a.m., with the Administrator, in the beauty shop confirmed the beauty shop was to be locked when unattended and confirmed the beauty shop was unattended and unlocked. F 333 : 483.25(m)(2) RESIDENTS FREE OF F 333 SS=D SIGNIFICANT MED ERRORS F333 The facility must ensure that residents are free of any significant medication errors. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, This REQUIREMENT is not met as evidenced by: Resident # 51 had an order obtain to continue sliding Based on observation, medical record review, scale on 9/11/12. review of the manufacturer's information, and interview, the facility failed to prevent a significant Resident #51 received insulin from backup pharmacy medication error for one (#51) of thirty-four on 9/11/12 insulin was given with no negative residents reviewed in Stage 2. outcomes nated.

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STATEMENT OF DEFICIENCIES	WAY SECTIONS				OMB NO	<u>. 09</u> 38-0391
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	445498	B. WII	NG_		09/1	2/2012
NAME OF PROVIDER OR SUPPLIER BRISTOL NURSING HOME			2	REET ADDRESS, CITY, STATE, ZIP CODE 61 NORTH STREET BRISTOL, TN 37625		2.2012
PREFIX (EACH DEFICIENT	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(X5) COMPLETION DATE
F 333 Continued From p	age 19	F	333	·		
October 13, 2006, Diabetes and Schi Diabetes and Schi Observation on Se revealed Licensed checked resident # of 179. Interview on Septe with LPN #2 revea Humalog insulin 2 to the blood sugar 10 units ordered to	admitted to the facility on with diagnoses including			How will you identify other residents ha potential to be affected by the same det practice and what corrective action will 100% review of all resident charts that rescale by the DON/ADON, and or Unit Marensure physician orders for sliding scale at 10/8/2012. What measures will be put into place or systematic changes you will make to ensideficient practice does not occur. Starting on 9/24/12 the Unit Managers wandits weekly for four weeks and then my two months of residents with sliding scale ensure the physician order is in place and available.	ficient he taken. eceive sliding nagers to are in place by what sure that the vill complete onthly for e insulin to d insulin is	
physician's recapit resident was to rec subcutaneously (by Continued review of physician's recapit orders for the resident insulin. Medical record review of Scale Insulin Order on March 26, 2012 have the blood glue and at hour of sleem 151 - 200 the resident Humalog insulin. Observation and in 2012, from 5:15 p.re	ulation orders revealed the seive Humalog insulin 10 units / injection) with meals. of the September 2012, ulation orders revealed no lent to receive sliding scale sew of a Subcutaneous Sliding Set, signed by the physician revealed the resident was to cose checked before meals p, and if the blood sugar was ent was to receive 2 units of terview on September 11, m., until 5:30 p.m., revealed e medication cart and the			Licensed nurses will be educated by the EUnit Manager, MDS nurse, or Night Super correct procedure for ordering insulin by Licensed nurses will be educated by the EUnit Manager, MDS nurse, or Night Super checking physician recapitulation orders to orders have been carried forward by 9/28 Starting after 9/28/12 staff will be in serviceing allowed to return to the floor. In-services will be added to the orientation	rvisor on the 9/24/12. PON/ADON, rvisor on to ensure all 8/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S COMPLE	
	445400	B. WING			
NAME OF PROMOTE OF CURRY SE	445498	<u> </u>			2/2012
BRISTOL NURSING HOME		26	EET ADDRESS, CITY, STATE, ZIP CODE 11 NORTH STREET RISTOL, TN 37625	Ē	
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
insulin, and confirme insulin available for a #51. Observation on Sepplem, revealed the redelivered to the residual of the redelivered to the residual. Observation on Sepplem, revealed the redelivered Humalog in facility's back-up phase of the supper meal. Observation on Sepplem, (45 minutes after the supper meal) revented Humalog 12 units supper meal) revented the supper meal of the sup	rigerator for the Humalog and there was no Humalog administration to resident tember 11, 2012, at 5:35 esident's supper meal was dent. tember 11, 2012, at 5:50 esident completed the supper tember 11, 2012, at 6:30 esident completed the supper stember 11, 2012, at 6:30 esident completed from the armacy to LPN #2. tember 11, 2012, at 6:35 fter the resident completed vealed LPN #2 administered abcutaneously into the facturer's information forHumalogis an injectable ede insulin. Humalog is used diabetes for control of high mould take Humalog within re eating or right after eating aber 11, 2012, at 6:38 p.m., insultant pharmacist insulin was to be fifteen to twenty minutes of	F 356	How the corrective action(s) will be mensure the deficient practice will not a sudit findings to the Quality Assurance monthly. The Quality Assurance Committee (Add Director of Nursing, and Assistant Director Medical Director, Business Office Manager, Activities Manager, Social Se Maintenance Director, and Therapy M make recommendations to revise or in process and determine when compliant achieved.	recur. Irse will report Committee ministrator, ctor of Nursing, ager, Dietary rvices Director, anager) will nprove the	completed 10/23/12

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 09/17/2012 A APPROVED): 0938-0391
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		TIPLE CONSTRUCTION	(X3) DATE S	BURVEY
······································	<u></u>	445498	B. WI	NG	<u></u>	09/1	12/2012
BRISTO	NURSING HOME				TREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET BRISTOL, TN 37625		12012
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	Continued From pa INFORMATION		F	356	6 F 356		
	a daily basis: o Facility name. o The current date. o The total number	st the following information on and the actual hours worked			What corrective action(s) will be accommand those residents found to have been affer deficient practice. No residents were affected.	plished for cted by the	
	unlicensed nursing : resident care per sh - Registered nur - Licensed pract				How will you identify other residents ha potential to be affected by the same del practice and what corrective action will All resident had the potential to be affect	licient be taken.	
	 Certified nurse o Resident census. 	aides.			Nursing staffing information was immediaby the Staff Coordinator on 9/10/12.		
	specified above on a of each shift. Data i o Clear and readabl	st the nurse staffing data a daily basis at the beginning must be posted as follows: e format. ce readily accessible to			What measures will be put into place or systematic changes you will make to ens deficient practice does not occur. On 9/10/12 the staffing coordinator was in the coordinator was in t	ure that the	
:	residents and visitor The facility must, up	s. on oral or written request, data available to the public			the OON on the need to post daily nursing hours.	g staffing	
	for review at a cost a standard.	not to exceed the community			Starting on 9/24/12 the DON/ADON will n nursing staffing posting daily for two wee weekly for two weeks and then monthly f months to ensure the nursing staffing dat	eks and then or two	
	staffing data for a m	intain the posted daily nurse inimum of 18 months, or as v, whichever is greater.				·	
-	by: Based on observation failed to post nurse s	T is not met as evidenced on and interview, the facility staffing data in a prominent ible to residents and visitors.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTI	PLE CONSTRUCTION	(X3) DATE S	
		ACTIVITION TOWNER.	A. BU	ILDIN	G	COMPL	ETED
	·	445498	B. Wil	4G		09/1	12/2012
	PROVIDER OR SUPPLIER L NURSING HOME			2	REET ADDRESS, CITY, STATE, ZIP CODE 61 NORTH STREET BRISTOL, TN 37625	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	MILD BE	(X5) COMPLETION DATE
F 356	Continued From pa	ge 22	F	356	How the corrective action(s) will be moni ensure the deficient practice will not recu	tored to	
	The findings include Observation on Sep	tember 10, 2012, at 10:30			The DON/ADON, Quality Assurance Nurse audit findings to the Quality Assurance Colmonthly for 3 months and PRN.	will report mmittee	
F 412 SS=D	Interview on Septen with the Scheduling Administrator, at the the nurse staffing date	nber 10, 2012, at 10:35 a.m., Coordinator and the nursing station confirmed ata was not posted.	F	112	The Quality Assurance Committee (Admini Director of Nursing, and Assistant Director Medical Director, Business Office Manager Manager, Activities Manager, Social Servici Maintenance Director, and Therapy Manage make recommendations to revise or impro process and determine when compliance has achieved.	of Nursing, r, Dietary es Director, ger) will ove the	completed in
	an outside resource §483.75(h) of this pa covered under the 5 dental services to m resident; must, if ne making appointmen transportation to and	art, routine (to the extent state plan); and emergency leet the needs of each cessary, assist the resident in ts; and by arranging for from the dentist's office; and residents with lost or			F 412 What corrective action(s) will be accomplise those residents found to have been affected deficient practice.	shed for ed by the	
	by: Based on medical r and interview, the fa	T is not met as evidenced ecord review, observation, cility failed to obtain dental dent (#32) of thirty-four n Stage 2.			Resident # 32 has a dental appointment sch 10/2/12 by the Social Services Director. How will you identify other residents havin potential to be affected by the same deficie practice and what corrective action will be All resident have the potential to be affected	ng the ent taken.	
- :	23, 2006, with diagn	imitted to the facility on May			100% record review by Nursing Administrati dental assessments will be completed by 10 ensure all assessments are current and accu care plan updated.	ion of /8/12 to	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	0: 09/17/201	2
		& MEDICAID SERVICES				OMB NO	MAPPROVE 0. 0938-039	1
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŧ	MULTIPLI IILDING	E CONSTRUCTION	(X3) DATE COMPI	SURVEY	
		445498	B. Wil	NG			400000	
NAME OF F	ROVIDER OR SUPPLIER		i	STREE	T ADDRESS OFTI		12/2012	_
BRISTO	L NURSING HOME			261	T ADDRESS, CITY, STATE, ZIP CODE NORTH STREET STOL, TN 37625			
(X4) IO	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.					4
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG	ΊX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 440	:	i		1	What measures will be put into place o	rwhat	<u> </u>	┪
F 412	Continued From page		F	412	systematic changes you will make to en	sure that the	1	ŀ
	Chronic Airway Obs	truction, Vascular Dementia,		!	deficient practice does not occur.	•		
		•		!	Starting on 9/24/12 the DON/ADON or L	Init Managers	j 	1
	Medical record review	w of the quarterly Minimum			will make weekly audits for four weeks	and then PRN	į	ı
	Data Set dated June	e 10, 2012, revealed the		•	of dental assessment on all residents to assessments are completed correctly.	ensure the		ı
	resident was able to	make needs known, and			ossessments are completed correctly.			ı
	understood what wa	is said.		1	Licensed staff will be educated by the DC	N/ADON, Uni	1	ł
	Medical record revis	ew revealed no documentation -		: 1	Managers, MDS nurse, or Night Supervis	or on	:	1
	the resident had rec	eived a dental consultation.		1	completing dental assessments correctly		:	
	Observation and into	erview on September 11,			Licensed nurses will be educated by the	DON/ADON,	1	ł
	2012, at 9:06 a.m., i	evealed the resident seated		. 1	Unit Managers, MDS nurse, or Night Sup	ervisor on	Ì	ı
	in a wheelchair in th	e dining room, and stated the			arranging dental services for any residen to have concerns with their teeth or den	that appears	ļ	Ī
	dentures were too to	ose, "they worry me all the			9/28/12.	tures by		ł
	time," and would like	to see a dentist.			CNAs will be educated by the DON/ADOI	N, Unit	-	
				• 1	Manager, MDS nurse, or Night Superviso	ron	:	ı
	Observation with the	Director of Nursing, on		i (communicating to the nurse with any an	d all resident	į.	
:	September 12, 2012	2, at 12:10 p.m., revealed the		: (concerns including dental concerns by 9/	24/12.	-	l
!	resident seated in a	wheelchair in the dining			Starting offer D/19/43 ato#		•	
:	regident at this time	and interview with the , revealed the resident's		1	Starting after 9/28/12 staff will be in serv being allowed to return to the floor.	iced prior to		ļ
	dentures were too lo	ose and sometimes caused		' '	semb anowed to return to the hoor.		:	
	problems with eating).			n-services will be added to the orientation	on packet.	:	
1	Interview on Santam	ber 12, 2012, at 1:55 p.m.,			How the corrective action(s) will be mor	nitored to		ı
	with the Director of N	Nursing (DON), in the DON's			ensure the deficient practice will not rec	tur.	!	
i		resident had not received a			The DON/ADON, Quality Assurance Nurse	e will report] ,	ļ
F 425	dental consultation.	MACELITICAL OVO			audit findings to the Quality Assurance Co	ommittee	1	İ
	483.60(a),(b) PHARI ACCURATE PROCE			: '	πonthly for 6 manths.			
	The facility must	rido reutino			The Quality Assurance Committee (Admir		į	ĺ
	drugs and biological	vide routine and emergency			Director of Nursing, and Assistant Directo		3	ĺ
		s to its residents, or obtain		: [Medical Director, Business Office Manage			
	them under an agree 8483 75(h) of this pa	irt. The facility may permit		. [Manager, Activities Manager, Social Servi	ices Director,	\ \'\\	
•	Angliceused personne	el to administer drugs if State			Maintenance Director, and Therapy Man make recommendations to revise or imp	ager) Will	compeyer	-
	law permits, but only	under the general			process and determine when compliance	has been	19/201	
	permito, but only	andor the Seneral			achieved.	100.01	i l	

DEPAR	IMENI OF HEALTH	HAND HUMAN SERVICES				PRINTEL	7: U9/17/2012
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NC	APPROVED 0. 0938-039
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE S	SURVEY
		445498	B WING	3		09/	12/2012
NAME OF P	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COD		12/2012
BRISTO	NURSING HOME			261	NORTH STREET	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	Continued From pa supervision of a lice		F 42	25	F 425		
	A facility must provi (including procedure acquiring, receiving	de pharmaceutical services es that assure the accurate , dispensing, and			What corrective action(s) will be according to have been af deficient practice. Resident # 51 had an order obtain to co	ffected by the	
;	the needs of each r	:			scale on 9/11/12, Resident # 51 received insulin from bac	ckup pharmacy	
!	a licensed pharmac	nploy or obtain the services of ist who provides consultation provision of pharmacy		i	on 9/11/12 insulin was given with no noutcomes noted.		
: :	services in the facili	ty.		:	How will you identify other residents is potential to be affected by the same d practice and what corrective action wi	leficient	
	by: Based on medical r	IT is not met as evidenced record review, observation, acility failed to provide		:	100% review of all resident charts that scale by the DON/ADON, and Unit Man physician orders for sliding scale are in 10/8/2012.	agers to ensure	
:	pharmacy services i (#51) of thrity-four r	in a timely manner for one residents reviewed.		-	What measures will be put into place of systematic changes you will make to end deficient practice does not occur.	or what Insure that the	
:	The findings include Resident #51 was a October 13, 2006, w Diabetes and Schize	dmitted to the facility on ith diagnoses including			Starting on 9/24/12 the Unit Managers chart audits of residents with sliding scaensure the physician order is in place ar available.	ale insulin to	
	Observation on Sep revealed Licensed F	tember 11, 2012, at 5:08 p.m, Practical Nurse (LPN) #2 of's blood sugar, with a result			Licensed nurses will be educated by the Unit Managers, MDS nurse, or Night Suj correct procedure for ordering insulin a the Physician order by 9/24/12.	pervisor on the	
:	with LPN revealed the Humalog insulin 2 un	nber 11, 2012, at 5:10 p.m., he resident was to receive nits per sliding scale related f 179, in addition to Humalog					

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES				PRINTE	D: 09/17/2012
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				FOR	MAPPROVED 0. 0938-039
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE	SURVEY
		445498	B. WIN	1G _			
NAME OF PE	ROVIDER OR SUPPLIER			ero	GET ADDRESS OFFI	09/	12/2012
BRISTOL	NURSING HOME			26	EET ADDRESS, CITY, STATE, ZIP CODE 11 NORTH STREET RISTOL, TN 37625		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PREF TAG	ıx :	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	DUI DIRE	(X5) COMPLETION DATE
	Medical record reviet physician's recapitures ident was to recessubcutaneously (by Medical record reviets Scale Insulin Order on March 26, 2012, have the blood gluciand at hour of sleep 151 - 200 the reside Humalog insulin. Observation and interest of the medication room refinsulin, and confirmentalin, and confirmentalin available for a facility's back-up phase in the supper meal) reviewed the medication on September 151. Observation on September 152 phase in the supper meal in the	be administered with meals. ew of the September 2012, lation orders revealed the eive Humalog insulin 10 units injection) with meals. ew of a Subcutaneous Sliding Set, signed by the physician revealed the resident was to ose checked before meals, and if the blood sugar was int was to receive 2 units of erview on September 11, until 5:30 p.m., revealed a medication cart and the rigerator for the Humalog administration to resident tember 11, 2012, at 6:30 acility's consultant pharmacist insulin, obtained from the	F	125	Licensed nurses will be educated by the Unit Managers, MDS nurse, or Night Sup checking physician recapitulation orders orders have been carried forward by 9/2 Starting after 9/28/12 staff will be in service being allowed to return to the floor. In-services will be added to the orientation that the corrective action(s) will be more ensure the deficient practice will not recommensure the Quality Assurance Nurse audit findings to the Quality Assurance Committee (Admir Director of Nursing, and Assistant Director Medical Director, Business Office Manager, Maintenance Director, and Therapy Manamake recommendations to revise or improrocess and determine when compliance achieved.	ervisor on to ensure all 8/12. riced prior to en packet. itored to ur. e will report emmittee elistrator, or of Nursing, or, Dietary ces Director, iger) will	(ampeted)

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/17/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445498 09/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 425 Continued From page 26 blood sugar... You should take Humalog within fifteen minutes before eating or right after eating a meal..." F 431 Interview on September 11, 2012, at 6:38 p.m., What corrective action(s) will be accomplished for with the facility's consultant pharmacist revealed those residents found to have been affected by the Humalog insulin was to be administered within deficient practice. fifteen to twenty minutes of the meal. 483.60(b), (d), (e) DRUG RECORDS, F 431 No residents were affected. SS=F , LABEL/STORE DRUGS & BIOLOGICALS How will you identify other residents having the The facility must employ or obtain the services of potential to be affected by the same deficient a licensed pharmacist who establishes a system practice and what corrective action will be taken. of records of receipt and disposition of all controlled drugs in sufficient detail to enable an All residents with orders for finger sticks have the accurate reconciliation; and determines that drug potential to be affected. records are in order and that an account of all controlled drugs is maintained and periodically Undated glucose strips on med carts were removed and replaced with glucose test strips that were dated reconciled. correctly on 9/11/12 by the half nurses. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted What measures will be put into place or what systematic changes you will make to ensure that the professional principles, and include the deficient practice does not occur. appropriate accessory and cautionary instructions, and the expiration date when Starting on 9/24/12 the Units managers will complete applicable. weekly audits for two weeks and then monthly for two months of med carts to ensure that glucose bottles are In accordance with State and Federal laws, the dated when opened. facility must store all drugs and biologicals in locked compartments under proper temperature Licensed nurses will be educated by the DON/ADON. controls, and permit only authorized personnel to Unit Managers, MDS nurse, or Night Supervisor on have access to the keys. dating glucose strips when opened by 9/28/12. The facility must provide separately locked, Starting after 9/28/12 staff will be in serviced prior to permanently affixed compartments for storage of being allowed to return to the floor. controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and In-services will be added to the orientation packet. Control Act of 1976 and other drugs subject to

STATEMENT	COC DECIDIENCIES	WAY ORGANISATION	$\overline{}$			OWR NO). 0 <u>938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIF ILDING	PLE CONSTRUCTION	(X3) DATE S COMPL	
		445498	B. Wi	4G		09/1	12/2012
	NURSING HOME			26	EET ADDRESS, CITY, STATE, ZIP CODE 61 NORTH STREET RISTOL, TN 37625		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	KÖÜLD BE	COMPLETION DATE
F 431	package drug distri	n the facility uses single unit bution systems in which the inimal and a missing dose can	F	431 [How the corrective action(s) will be mensure the deficient practice will not r The DON/ADON, Quality Assurance Nuaudit findings to the Quality Assurance monthly for 3 months.	recur. rse will report	
	by: Based on observat interview, the facility	NT is not met as evidenced ion, facility policy review and railed to ensure proper and as and biologicals in three of carts observed.			The Quality Assurance Committee (Adr Director of Nursing, and Assistant Direc Medical Director, Business Office Mana Manager, Activities Manager, Social Sel Maintenance Director, and Therapy Ma make recommendations to revise or im process and determine when compliant achieved.	ctor of Nursing, ager, Dietary rvices Director, anager) will aprove the	computation 12
	September 11, 2012 Practical Nurse (LP medication room, reglucose test strips of Review of facility polymetric Medication Container floor's stock medical necessary informatidate when applicable	ong half medication cart on 2, at 4:15 p.m., with Licensed N) #5 in the First Tennessee evealed one bottle of thirty-five expend and undated. licy entitled Labeling of ears revealed"Labels for each tions shall include all on, such asthe expiration e."					
	4:15 p.m., confirmed strips had not been Observation of the s September 11, 2012 in the Second Tenno	short hall medication cart on 2, at 6:10 p.m., with LPN #3, essee medication room four glucose test strips					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/17/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445498 09/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET** BRISTOL NURSING HOME BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID . PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 431 Continued From page 28 F 431 Interview with LPN #3, on September 11, 2012, at 6:10 p.m., in the Second Tennessee medication room confirmed the bottle of the glucose test strips were opened and undated. Observation of the long hall medication cart on September 11, 2012, at 6:20 p.m., with LPN #1, in the Second Tennessee medication room revealed a bottle of thirteen glucose test strips opened and undated. Interview with the Director of Nursing on September 12, 2012, at 8:00 a.m., in the conference room confirmed the facility failed to properly label and store the blood glucose strips. F 464 483.70(g) REQUIREMENTS FOR DINING & F 464 SS=E ACTIVITY ROOMS F 464 The facility must provide one or more rooms designated for resident dining and activities. What corrective action(s) will be accomplished for those residents found to have been affected by the These rooms must be well lighted; be well deficient practice. ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space On 9/10/12 extra tables were brought into the dinning to accommodate all activities. room to accommodate resident's needs by maintenance. This REQUIREMENT is not met as evidenced No negative outcomes noted thru observation. by: Based on observation and interview the facility How will you identify other residents having the failed to adequately furnish a designated dining potential to be affected by the same deficient area to accommodate resident needs for 12 practice and what corrective action will be taken. residents (#57,#31,#29,#135,#112, #25, #24, #136, #105, #39 #94, #23) in one of two dining Starting on 9/24/12 "All Hands on Deck" department heads will be assigned units to assist in passing trays rooms. out and set up when available.

Observation on September 10, 2012, from 12:17p.m. through 1:10p.m., in the second floor

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
	YT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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	445498		B. WING			09/12/2012	
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		IAILU IA
BRISTO	L NURSING HOME			26	61 NORTH STREET RISTOL, TN 37625	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 464 : Continued From page 29 dayroom, revealed the room was inadequately furnished to accommodate the needs of residents			F 464 What measures will be put into place systematic changes you will make to e deficient practice cloes not occur.			or what insure that the	
	who regularly dine in this area. Twelve residents were present at the time of the observation. Two of the residents were ambulatory with walkers, the others were propelling in wheelchairs, or reclined in geri-chairs. The room was furnished				Starting on 9/24/12 the Unit Managers meal services dally for two weeks and four weeks and then PRN to ensure cor procedures and resident dignity during being followed.	then weekly for rect dinning	
	two four seat tables minute dining observesidents seated at the large table) and	es, one eight seat table, and At no time during the 53 vation were more than four any of the tables (including four of the residents (#29,			The DON/ADON, Unit Manager, MDS N Supervisor will educate the nursing stat dinning procedures and resident dignity by 9/28/2012.	f on correct	
	while seated in thei (#94) had to wait fo meal until a bedside hold the meal tray.	re fed from bedside tables r geri-chairs. One resident r other residents to finish their e table became available to This resident waited 40			Starting after 9/28/12 staff will be in ser process for meal services to ensure mea timely prior to being allowed to return to	Is are served	
	minutes after the tra begin eating the me	ays arrived on the floor to			In-service will be added to the orientation	n packet.	
	observation, reveale	# 3, at the time of the ed the furnishings were sparse flow the residents to dine nultaneously.		: !	How the corrective action(s) will be mo ensure the deficient practice will not re	nitored to Cur.	
	2012, at 12:55, in the time of the obse	dministrator, September 10, e second floor dayroom, at rvation, confirmed the idequate to accommodate the			The DON/ADON, Quality Assurance Nurs audit findings to the Quality Assurance C monthly for 6 months.	e will report committee	
F 500	residents' dining ne 483.75(h) OUTSIDE RESOURCES-ARR	eds. E PROFESSIONAL		1:	The Quality Assurance Committee (Admit Director of Nursing, and Assistant Director Medical Director, Business Office Manag Manager, Activities Manager, Social Serv	or of Nursing, er, Dietary	
	to be provided by th have that service fu	ot employ a qualified to furnish a specific service e facility, the facility must rnished to residents by a utside the facility under an		1	Maintenance Director, and Therapy Man make recommendations to revise or imp process and determine when compliance achieved.	ager) will rove the	completed

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 09/17/2012 MAPPROVED
		& MEDICAID SERVICES	,			OMB NO). <u>0938-</u> 0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445498	B. WI	NG.		004	10100.40
NAME OF F	ROVIDER OR SUPPLIER		L	T _{e7}	DEET ADDRESS OFFICE CO.		12/2012
BRISTO	L NURSING HOME				261 NORTH STREET	E	
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		SHOULD BE	(X5) COMPLETION DATE	
F 500	Continued From pa	ne 30				···	
	arrangement descri Act or an agreemer	bed in section 1861(w) of the at described in paragraph (h)	F	500	F 500		
	(2) of this section. Arrangements as de	escribed in section 1861(w) of			what corrective action(s) will be according the residents found to have been a deficient practice.	mplished for ffected by the	
	furnished by outside writing that the facili	nts pertaining to services resources must specify in ity assumes responsibility for that meet professional	MIRER: (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIANCE A BUILDING (X3) DATE S COMPLIANCE B WING (X3) DATE S COMPLIANCE STREET ADDRESS. CITY, STATE, ZIP CODE 261 NORTH STREET BRISTOL, TN 37625 S				
:	standards and princ	iples that apply to ling services in such a facility:			potential to be affected by the same of	feficient	
	This REQUIREMEN	IT is not met as evidenced			completed done to ensure diatysis info	ilalysis will be metion has	
	Based on medical r the facility failed to e between the facility resident #123 of thir	ecord review and interview ensure communication and the dialysis center for one ty-four residents reviewed in			systematic changes you will make to e deficient practice does not occur.	nsure that the	
:	stage 2. The findings reveale	; ed:			checks of patient charts with dialysis to	I make audit ensure	
:	June 20, 2012, with	admitted to the facility on diagnosis including Chronic betes Mellitus, Congestive yperlipidemia.			Unit Manager, MDS nurse, or Night 5us provide communication to and followin dialysis center if resident returns witho	ervisor on Ig up with the	
	dated July 6, 2012, r times a week" Cor	w of the resident care plan evealed "Dialysis 3(three) itinued record review intation between the dialysis			Starting after 9/28/12 staff will be in se	rviced prior to	
	center and the facilit	y to communicate the or after receiving a dialysis			in-service will be added to the orientati	on packet.	
:	Interview and media	record review with the					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTER): 09/17/2012 APPROVED	
		& MEDICAID SERVICES				OMB NO). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445498	B. WING			22/12/2		
	ROVIDER OR SUPPLIER NURSING HOME		1	26	EET ADDRESS, CITY, STATE, ZIP CODE 11 NORTH STREET RISTOL, TN 37625		2/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	J'EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 500	Continued From pa Director of Nursing 2012, at 3:45 p.m., confirmed the facilit communication with	(DON) on September 12, in the first floor dining room, y failed to ensure	F:	500	How the corrective action(s) will be monitensure the deficient practice will not rectangular the deficient practice will not rectangular the deficient practice will not rectangular the deficient practice will not rectangular the deficient to the Quality Assurance Commonthly for 6 months. The Quality Assurance Committee (Adminitent Director of Nursing, and Assistant Director Medical Director, Business Office Manager, Manager, Activities Manager, Social Servicient Maintenance Director, and Therapy Managular make recommendations to revise or improprocess and determine when compliance is achieved.	will report mmittee istrator, of Nursing, r, Dietary es Director, ger) will we the	المدادا	
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